FSA Worksheets

Deciding How Much to Deposit

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the calendar and plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS guidelines for calendar or plan year limits. (Refer to the individual FSA descriptions in this booklet for limits.) **Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.**

TAX-FREE HEALTHCARE WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year, which is January 1, 2004, through December 31, 2004.

YOUR UNINSURED MEDICAL, DENTAL AND VISION EXPENSES

_____ $_____

_____ $_____

_____ $_____

_____ $_____

_____ $_____

SUBTOTAL

Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed $4,967.50.

Enter this amount in Section 3A of your PlanYear 2004 Miami-Dade Benefits Election Form. = $ _____
cannot exceed $4,967.50 (plus administrative fee)

DIVIDE

by the number of paychecks with deductions you will receive during the plan year (26)*. ÷ _____

This is your pay period contribution = $ _____

Remember to review your first paycheck to be certain the correct amount has been reduced from your salary ($191.05 maximum per pay period).

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

TAX-FREE DEPENDENT CARE WORKSHEET

Estimate your eligible dependent care expenses for the plan year, which is January 1, 2004, through December 31, 2004.

NUMBER OF WEEKS

you will have dependent (child, adult or elder) care expenses during the plan year.
Remember to subtract holidays, vacations and other times you may not be paying for eligible child, adult or elder care. = _____

MULTIPLY

by the amount of money you expect to spend each week. **X** $ _____

SUBTOTAL

Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed $4,967.50.

Enter this amount in Section 3B of your Plan Year 2004 Miami-Dade Benefits Election Form. = $ _____
cannot exceed $4,967.50 (plus administrative fee)

DIVIDE

by the number of pay periods during the plan year (26)*. ÷ _____

This is your pay period contribution = $ _____

Remember to review your first paycheck to be certain the correct amount has been reduced from your salary ($191.05 maximum per pay period).

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Refer to the Healthcare FSA section for a partial list of eligible expenses.

At your request, your FSA checks may be deposited into your checking or savings account by enrolling in Direct Deposit.